U.S. Department of Labor

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Issue Date: 20 September 2002

CASE NO.: 2001-BLA-00195

In the Matter of

JOSEPH CRESS
Claimant

v.

JEDDO-HIGHLAND COAL CO.
Employer

LACKAWANNA CASUALTY COMPANY
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

Helen M. Koschoff, Esquire
For Claimant

John J. Notariani, Esquire
For Employer/Carrier

Before: ROBERT D. KAPLAN
Administrative Law Judge

DECISION AND ORDER
DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901, et seq., (the Act) and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations.[1] Regulations referred to herein are contained in that Title.

[1]Unless otherwise noted, the regulations referred to herein are the revised regulations effective January 19, 2001, found at 20 C.F.R. Part 718 (2002).

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

On November 27, 2000, this case was referred to the Office of Administrative Law Judges for a formal hearing. Subsequently the case was assigned to Administrative Law Judge ("ALJ") Ainsworth H. Brown who conducted a hearing on March 12, 2002, in Reading, Pennsylvania, where the parties had full opportunity to present evidence and argument. Due to the death of Judge Brown, this case subsequently was assigned to me to decide on the record. Employer/Carrier (hereinafter, "Employer") filed a brief on August 7, 2002. Claimant did not file a post-hearing brief. This decision is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The parties stipulated that Claimant has established a coal mine employment history totaling 39 years. (T 23)[2]

The specific issues presented for resolution are:

1. Whether Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether Claimant's pneumoconiosis arose out of coal mine employment.

3. Whether Claimant is totally disabled.

4. Whether Claimant's disability is due to pneumoconiosis.

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[2]The following abbreviations are used herein: "DX" refers to Director's Exhibit; "CX" refers to Claimant's Exhibit; "EX" refers to Employer's Exhibit; "T" refers to the transcript of the March 12, 2002 hearing.

The following exhibits, which are individually described below, were submitted post-hearing in accordance with prior rulings and are herewith received in evidence: CX 20 - 25 and EX 22.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Claimant filed a claim for benefits on July 27, 1998. (DX 1) On April 20, 2000, ALJ Lawrence P. Donnelly issued a Decision and Order ("D&O") in which he found that the evidence of record at that time failed to establish the presence of pneumoconiosis or that Claimant was totally disabled. However, Judge Donnelly remanded the case to the District Director for the purpose of providing Claimant with a complete credible medical examination (pursuant to §§725.405(b), 725.406, and 725.407). Employer moved for reconsideration of ALJ Donnelly's determination and for an outright denial of the claim. (DX 42) On June 1, 2000, the relief requested by Employer was denied by the undersigned. (DX 43)

The directed examination was performed at the behest of the District Director. Subsequently, the District Director denied the claim on July 28, 2000. (DX 49) On August 24, 2000, Claimant requested a formal hearing (DX 53) that was conducted by ALJ Brown on March 12, 2002. After the case was again referred to the Office of Administrative Law Judges, on June 1, 2000, I issued a Supplemental Decision and Order in which I rejected Employer's argument that Judge Donnelly erred in remanding the case to obtain additional medical evidence rather simply denying the claim. (DX 43)

B. Factual Background;

Claimant was born on June 26, 1932, and married Elizabeth Banning on April 3, 1954. Claimant's spouse is his only dependent for purposes of augmentation of benefits under the Act. (DX 1)

At the hearing before ALJ Brown on March 12, 2002, Claimant testified that his breathing problems are worse than they were at the time he testified before Judge Donnelly in June 1999. He has a productive cough. He has never smoked tobacco products. Claimant stated that he becomes short of breath after walking one-half block or up six or seven steps. He stated that he is unable to perform his last coal mine employment. Claimant testified that he uses an inhaler and a nebulizer prescribed by Dr. Raymond Kraynak and Dr. John Simelaro. The only other medication he takes regularly is aspirin which was prescribed by his heart specialist, Dr. Swayne. Claimant testified that he underwent open-heart surgery seven months prior to the March 2002 hearing. He professed not to know whether the surgery was "coronary bypass surgery." (T 25-31) However, both Dr. Thomas Dittman and Dr. Simelaro noted that Claimant underwent triple coronary artery bypass surgery in July 2001. (CX 22, p. 35; EX 19, p. 9)

C. Entitlement

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under Part 718 standards. § 718.2. In order to establish entitlement to benefits under Part 718, Claimant must prove that he has pneumoconiosis, that it arose out of his coal mine employment, and that the pneumoconiosis has caused him to be totally disabled. Claimant has the burden

of establishing each element of entitlement by a preponderance of the evidence. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

The Department of Labor has issued new Part 718 regulations, most of which are effective with regard to claims pending on January 19, 2001. §725.2 (2002) However, the new quality standards apply only to evidence developed after January 19, 2001. §718.101(b)(2002). Further, the new §718.101(b) states:

> Any clinical test or examination subject to these standards shall be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. Unless otherwise provided, any evidence which is not in substantial compliance with the applicable standard is insufficient to establish the fact for which it is proffered.

As noted above, in his D&O of April 20, 2000, ALJ Donnelly found that the evidence before him failed to establish the presence of pneumoconiosis or total disability due to a respiratory or pulmonary condition. I have reviewed the evidence that was in the record that was before Judge Donnelly and agree with his findings that this evidence as a whole fails to establish the presence of pneumoconiosis or total disability due to a respiratory or pulmonary condition. Judge Donnelly's analysis and findings are incorporated herein.

Based on the foregoing, I need consider only the evidence that pertains to the period subsequent to the issuance of Judge Donnelly's D&O on April 20, 2000.[3]

1. Proof of Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §718.202(a)(1) through (4):

a. X-ray evidence. §718.202(a)(1).
b. Biopsy or autopsy evidence. §718.202(a)(2).
c. Regulatory presumptions. §718.202(a)(3).

[3]Some new interpretations of the pre-April 20, 2000 laboratory tests and X-rays were submitted after Judge Donnelly remanded the case. This evidence should have been submitted to Judge Donnelly, and I therefore find that it need not be considered at this juncture of the case. Further, as pneumoconiosis is a progressive and irreversible disease, the post-April 20, 2000 medical evidence is entitled to significantly greater weight than the earlier evidence in determining whether Claimant has established the presence of pneumoconiosis and that he is totally disabled due to pneumoconiosis.

(1) §718.304 - Irrebuttable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.

(2) §718.305 - Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven 15 years of coal mine employment and there is other evidence demonstrating the existence of a totally disabling respiratory or pulmonary impairment.

(3) §718.306 - Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978, and was employed in one or more coal mines prior to June 30, 1971.

d. Physicians' opinions based upon objective medical evidence. §718.202(a)(4).

The U.S. Court of Appeals for the Third Circuit has held that, in considering whether the presence of pneumoconiosis has been established, "all types of relevant evidence must be weighed together to determine whether the claimant suffers from the disease." Penn Allegheny Coal Co. v. Williams, 114 F.3d 22 (3d Cir. 1997).[4]

X-ray evidence, §718.202(a)(1)

Under §718.202(a)(1) the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with §718.102. The current record contains the X-ray interpretations summarized in the following table:

DATE OF X-RAY	DATE READ	EX. NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	INTERP.
5/23/00	5/23/00	DX 47	Gaia	B	1/1
5/23/00	6/7/00	DX 47	Gaziano[5]	BCR	1/1

[4]This case arises in the jurisdiction of the Third Circuit because Claimant's coal mine employment took place in Pennsylvania.

[5]Drs. Gaia and Gaziano interpreted the May 23, 2000 film at the behest of the Department of Labor. At the hearing, Employer concurred in ALJ Brown's ruling that three interpretations of the film by Employer's experts (DX 46 and DX 50) should be excluded from the record. (T 8-9)

DATE OF X-RAY	DATE READ	EX. NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	INTERP.
11/2/00	12/15/00	EX 9	Duncan	BCR, B	0/0
11/2/00	1/26/01	EX 10	Laucks	BCR, B	0/0
11/2/00	2/12/01	CX 14	Miller	BCR, B	1/1
11/2/00[6]	2/17/01	CX 15	Cappiello	BCR, B	1/2
2/22/02	2/22/02	EX 17	Ciotola	Not of record	0/1
2/22/02	3/21/02	EX 22	Sondheim	BCR, B	0/0
2/22/02	4/27/02	CX 21	Brandon	BCR, B	1/2
2/22/02	5/31/02	CX 24	Miller	BCR, B	1/1

A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. §37.51. A physician who is a Board-certified radiologist ("BCR") has received certification in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. §727.206(b)(2)(iii).

Section 718.102(e) and Appendix A establish the quality standards for X-rays. New §718.102(e) states, in part:

> Except as provided in this paragraph, no chest X-ray shall constitute evidence of the presence or absence of pneumoconiosis unless it is conducted and reported in accordance with the requirements of this section and Appendix A. In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed.

It is well-established that the interpretation of an X-ray by a B-reader may be given additional weight by the fact finder. Aimone v. Morrison Knudson Co., 8 BLR 1-32, 34 (1985); Martin v. Director, 6 BLR 1-535, 537 (1983); Sharpless v. Califano, 585 F.2d 664, 666-67 (4th Cir. 1978). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a B-reader as well

[6]Claimant and Employer agreed to limit their interpretations of the November 2, 2000 film to three each. Consequently, Employer withdrew its additional interpretations of this film. (T19-20) However, since there is some confusion about which films would be withdrawn, I have limited each side to two interpretations.

as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. Scheckler v. Clinchfield Coal Co., 7 BLR 1-128, 131 (1984).

The film taken on May 23, 2000 was interpreted solely as positive for pneumoconiosis. The film taken on November 2, 2000 was interpreted by an equal number of dually qualified radiologists as positive and as negative. Thus, the evidence relating to this X-ray is in balance, and the film can be considered neither positive nor negative. Finally, the X-ray of February 22, 2002 was interpreted as positive by two radiologists and as negative by two radiologists. However, the record reveals that both physicians who read the film as positive are dually qualified, while the qualifications of one of the physicians who interpreted the film to be negative is not of record. Consequently, the two positive interpretations of the most current X-ray are entitled to greater weight than the two negative readings. In light of the above, I find the X-ray evidence as a whole supports a finding that Claimant has pneumoconiosis.

Biopsy or autopsy evidence, §718.202(a)(2)

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. §718.202(a)(2). That method is unavailable here, because the record contains no such evidence.

Regulatory presumptions, §718.202(a)(3)

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§718.304, 718.305 and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions are applicable, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physicians' opinions, §718.202(a)(4)

The fourth way to establish the existence of pneumoconiosis under §718.202 is set forth as follows in subparagraph (a)(4):

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

As noted above, §718.201(a)(2002) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis." Sections 718.201(a)(1) and (2) define clinical pneumoconiosis and legal pneumoconiosis. Section 718.201(b) states:

> [A] disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

In addition, §718.201(c) provides that pneumoconiosis is a "latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure."

Section §718.104(a)(2002) (effective with regard to evidence developed after January 19, 2001) requires that a physician's report of a physical examination contain the miner's medical and employment history, all manifestations of chronic respiratory disease, if heart disease secondary to lung disease is found, all symptoms and significant findings, and the results of a chest X-ray, and a pulmonary function test unless contraindicated.

Dr. Dinesh Talati (Board certified in internal medicine and pulmonary disease) examined Claimant at the behest of the Department on June 20, 2000, and signed a report on July 14, 2000. (DX 47) The physician stated a diagnosis of simple pneumoconiosis caused by coal dust exposure. It appears that Dr. Talati relied primarily on Claimant's coal mine employment history of 39 years and the two positive interpretations of the X-ray taken on May 23, 2000, in conjunction with his examination. Dr. Talati also referred to Claimant's symptoms, laboratory studies and his clinical findings. I find that the physician's opinion is reasoned and documented.

Dr. Sander Levinson (Board certified in internal medicine and pulmonary disease) testified in a deposition on June 20, 2000. (DX 51) The physician reviewed much of the evidence that was before Judge Donnelly and concluded that Claimant did not have pneumoconiosis. Dr. Levinson relied on outdated evidence. Moreover, the physician was not aware of the current X-ray evidence which I have found supports a finding of the presence of pneumoconiosis. Therefore , I find that his opinion on this subject is not documented.

Dr. Stephen Kruk (Board certified in internal medicine) provided a brief report dated April 18, 2001 in which he stated that he examined Claimant on that date and opined that Claimant had coal workers' pneumoconiosis. (CX 4) Dr. Kruk relied on Claimant's coal mine employment history, his symptoms, and his April 1999 examination, whose findings were not stated in his current report. As Dr. Kruk failed to provide a substantial basis for his opinion, I find that it is not reasoned or documented. Dr. Raymond Kraynak (Board eligible in family medicine) testified in a deposition on May 4, 2001. (CX 1) Dr. Kraynak testified that he has been treating Claimant and sees him every two months. The physician noted Claimant's coal mine employment history, and his symptoms of shortness of breath and a cough. His clinical findings were cyanotic lips and scattered wheezes. Dr. Kraynak referred to both negative and positive X-ray interpretations as well as some old and some current ventilatory studies (which will be discussed below). He concluded that Claimant has

pneumoconiosis arising out of his coal mine employment. I find that Dr. Kraynak's opinion that Claimant has pneumoconiosis is reasoned and documented.

Dr. Jonathan Hertz (Board certified in internal medicine, pulmonary disease, and critical care medicine) issued a report dated November 12, 2000 based on his examination of Claimant on November 2, 2000. (EX 7) The physician noted Claimant's coal mine employment history, symptoms and negative clinical findings. Dr. Hertz also referred to ventilatory studies which he stated indicated that Claimant had no pulmonary impairment. Dr. Hertz referred to his interpretation of the chest X-ray taken on November 2, 2000 (which interpretation Employer has agreed to withdraw). Dr. Hertz opined that there was no evidence of coal workers' pneumoconiosis. I find that this opinion of Dr. Hertz is reasoned and documented. Dr. Hertz provided a follow-up report dated December 12, 2000, in which he discussed the disability question. (EX 8) In addition, the physician was deposed on June 26, 2001. (EX 16) At that time, with respect to the pneumoconiosis question, Dr. Hertz testified that Claimant did not have coal workers' pneumoconiosis "or any other identifiable lung disease" and that he could draw that conclusion even without having X-ray evidence. (EX 16, pp. 22-23)

Dr. John Simelaro (Board certified in internal medicine and pulmonary disease) issued current reports dated July 18, 2000, January 11, 2001 and June 7, 2001 (CX 18) Dr. Simelaro referred to Claimant's coal mine employment history, symptoms and laboratory studies and unidentified positive X-ray interpretations. The physician testified in a deposition on April 9, 2002. (CX 22) At that time he stated that he had treated Claimant since August 20, 1999. He noted Claimant's coal mine employment history, symptoms of shortness of breath and productive cough, without chest pain, and clinical findings from time to time of marked decreased breath sounds, wheezes, and scattered rhonchi. He last examined Claimant in December 2001. Dr. Simelaro also referred to a number of laboratory studies. He noted that there were conflicting X-ray interpretations and testified that since Claimant had never smoked tobacco products, his diagnosis of pneumoconiosis in Claimant was made relying on Claimant's pulmonary symptoms and his coal mine employment history. The physician testified that by "process of elimination" he concluded that pneumoconiosis was the cause of the symptoms, stating, "[W]hat else would cause it?" (CX 22, p. 22) Dr. Simelaro also noted that Claimant had undergone triple coronary artery bypass surgery in July 2001, and stated that the surgery was successful. (CX 22, P. 35) I find that Dr. Simelaro's opinion is reasoned and documented.

Dr. Thomas Dittman (Board certified in internal medicine) examined Claimant on February 22, 2002 and issued a report dated March 5, 2002. (EX 17) Dr. Dittman referred to Claimant's symptoms, coal mine employment history, his negative clinical findings, Dr. Ciotola's negative X-ray interpretation, and laboratory studies performed at that time. Dr. Dittman opined that Claimant did not have pneumoconiosis. The physician diagnosed coronary artery disease, status post coronary artery surgery. Dr. Dittman testified in a deposition on May 3, 2002, in which he reiterated the foregoing. (EX 19) I find that Dr. Dittman's opinion is reasoned and documented.

The acceptable opinions of Drs. Kraynak, Talati, Simelaro, Hertz and Dittman are more or less balanced, although Dr. Kraynak's qualifications are inferior to those of the other three physicians. I find that the physicians' opinion evidence that supports a finding of the presence of pneumoconiosis (Drs. Kraynak, Talati and Simelaro) slightly outweighs the contrary reasoned opinions of Drs. Hertz and Dittman.

Weighing the Medical Evidence, §718.202(a)

Weighing all the medical evidence together, I find that the current positive X-ray evidence constitutes the best evidence of Claimant's pulmonary status. This evidence is supported by the physicians' opinion evidence which slightly favors a finding of the presence of pneumoconiosis. Based on the foregoing consideration of all the relevant evidence, I find that the presence of pneumoconiosis has been established, pursuant to §718.202(a).

2. Pneumoconiosis Arising out of Coal Mine Employment

Claimant must next establish that his pneumoconiosis arose at least in part out of coal mine employment. §718.203(a). Miners with a coal mining history of at least 10 years benefit from a rebuttable presumption that the pneumoconiosis arose out of such employment. §718.203(b). Where a miner with pneumoconiosis was employed less than 10 years in coal mining, "it shall be determined that such pneumoconiosis arose out of that employment only if competent evidence establishes such a relationship." §718.203(c).

Claimant has established 39 years of coal mine employment. The record contains no evidence rebutting the presumption that Claimant's coal mine employment caused his pneumoconiosis. Therefore, I find that Claimant has established that his pneumoconiosis arose out of coal mine employment.

3. Total Disability

Claimant first must establish that he is totally disabled due to a respiratory or pulmonary condition. Total disability is defined in §718.204(b)(1) as follows:

> [A] miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner (i) From performing his or her usual coal mine work; and (ii) From engaging in [other] gainful employment ....

Nonpulmonary and nonrespiratory conditions which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability under the Act. §718.204(a) (effective January 19, 2001). See also Beatty v. Danri Corp., 16 BLR 1-1 (1991), aff'd as Beatty v. Danri Corp. & Triangle Enterprises, 49 F.3d 993, 1000 (3d Cir. 1995). However, the new §718.204(a) further provides:

> If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner was totally disabled [under the Act].

Section 718.204(b)(2) sets forth the criteria for establishing total disability. A presumption of total disability is not established by a showing of evidence qualifying under a subsection of §718.204(b)(2), but rather such evidence shall establish total disability in the absence of contrary

evidence of greater weight. *See* Gee v. W.G. Moore & Sons, 9 BLR 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. Rafferty v. Jones & Laughlin Steel Corp., 9 BLR 1-231 (1987).

As noted, I shall here consider only the current (post-April 20, 2000) evidence.

Claimant may establish total disability by four kinds of evidence: pulmonary function study; arterial blood gas study; evidence of cor pulmonale with right-sided congestive heart failure; and reasoned medical opinion. §718.204(b)(2)(i)-(iv).

In order to establish total disability through pulmonary function tests (i.e., by "qualifying" tests), the FEV-1 must be equal to or less than the values listed in Table B1 (males) or Table B2 (females) of Appendix B to this part and, in addition, the tests must reveal either: (1) values equal to or less than those listed in Table B3 (males) or Table B4 (females) for the FVC test, or (2) values equal to or less than those listed in Table B5 (males) Table B6 (females) for the MVV test or, (3) a percentage of 55 or less when the results of the FEV-1 test are divided by the results of the FVC test. §718.204(b)(2)(i)(A)-(C).

The record contains a number of pulmonary function studies which must be weighed in accordance with §718.204(c)(1)(2000) and §718.204(b)(2)(i) (effective January 19, 2001). Any ventilatory study performed after January 19, 2001, must contain the results of flow versus volume (flow-volume loop) and the FEV-1 /FVC ratio expressed as a percentage. §§718.101(b) and 718.103(a).

The current pulmonary function studies of record are summarized below :

DATE	EX. NO.	PHYSICIAN	AGE	FEV_1	FVC	MVV	FEV_1/ FVC	EFFORT	QUALIFIES
6/28/00	DX 47	Talati	68	1.98	3.02	66	65%	Good	No
9/14/00	CX 2	Kraynak	68	1.49	2.18	54	68%	Good	Yes
11/2/00	EX 7	Hertz	68	2.09 2.20*	3.05 3.47*	57 61*	68% 63%*	Unsuff. " *	No " *
9/13/01	CX 3	Kraynak	69	1.76	2.89	63	60%	Good	Yes
12/4/01	CX 18	Simelaro	69	2.00	2.79	–	71%	–	No
2/22/02	EX 17	Dittman	69	1.89 1.80*	4.84 3.21*	52 53*	39% 56%*	Incons't " *	No " *

* post-bronchodilator

Assessment of pulmonary function study results are dependent on Claimant's height, which was recorded most frequently as 68 inches. I have used that height in evaluating the studies. Protopappas v. Director, 6 BLR 1-221 (1983).

Dr. Levinson reviewed the pulmonary function study of June 28, 2000, stating that the FEV-1 and FVC maneuvers are valid but the MVV is not valid due to variable and inconsistent effort and only one attempt being reported. (DX 56) Dr. Robin Kaplan (Board certified in internal medicine) stated that this ventilatory study was valid, but that the MVV was moderately reduced due to less than maximal effort. (EX 56) Dr. Hertz testified that the study is not valid due to excessive variability in the tracings. (EX 16, p. 18) Dr. Kraynak testified that he disagreed with Dr. Levinson's and Dr. Kaplan's opinion that the MVV was reduced due to insufficient effort. Dr. Kraynak found that there was good effort throughout the study. (CX 1, p. 11; CX 20) Weighing the foregoing opinions, only Dr. Hertz concluded that the study's FEV-1 and FVC are invalid. Therefore , I find that the evidence establishes that these maneuvers are valid. Only Dr. Levinson found that the MVV is valid. Therefore, I find that the MVV is not valid.

Dr. Hertz opined that the ventilatory study performed on September 14, 2000, is not valid due to inadequate effort. (EX 16, pp. 21-22) Dr. Levinson and Dr. Kaplan also found the study invalid because of improper tracings and inconsistent effort. (EX 14) Dr. Kraynak stated that there was good effort and the study is valid. (CX 1, pp. 7, 22; CX 8, 9) As the opinion of Dr. Kraynak is heavily outweighed by the contrary opinion of the three other physicians, I find that the study is not valid.

Dr. Hertz testified that the Claimant's effort in his study of November 2, 2000, was less than maximal. Nevertheless, Dr. Hertz stated, the FEV-1 and FVC values attained in this study indicate Claimant's lung function was very well preserved. (EX 16, pp. 9-10,14-15, 34, 39) Dr. Kraynak also testified that this study is not valid. Further, Dr. Kraynak speculated that this study could have resulted in higher values than Claimant could achieve if Claimant had coughed, removed the mouthpiece from his mouth, and then taken additional inhalations. (CX 1, pp. 15-16) Based on the foregoing, I find that the study performed on November 2, 2000 is not valid. However, the import of the study, based on the two physicians' analyses, will be discussed below.

Dr. Levinson opined that the study of September 13, 2001 is not valid due to gaps or discontinuances in the FVC tracings and variable curves in the MVV tracings. Dr. Levinson stated that the values are an underestimation of Claimant's actual pulmonary capacity. (EX 20) Dr. Kraynak testified that he disagreed with Dr. Levinson and that there was good effort and the study is valid. (CX 23) As Dr. Levinson's qualifications are superior to those of Dr. Kraynak, I give the former's opinion greater weight. I therefore find that this study is not valid.

Dr. Levinson opined that the study performed on December 4, 2001 is not valid. The physician stated that there was no recording of the inhalation or the flow volume curves. Further, Dr. Levinson opined that there was excessive variability of the FEV-1 tracings. (EX 18) In a report dated July 17, 2002, Dr. Simelaro stated that the study was acceptable for "clinical only" because of : "Too much variation [and] Not enough spirograms." Consequently, I find that this study is not valid.

The study of February 22, 2002 was performed under the aegis of Dr. Dittman and found by him to be invalid due to Claimant's inconsistent effort. However, Dr. Dittman relied on this study in stating his opinion regarding the disability question. (Ex 19, pp. 18-21, 30) Dr. Dittman's reliance on this study will be considered below. Total disability may also be established with qualifying arterial

blood gas tests showing values listed in Appendix C. §§718.204(c)(2) and 718.204(b)(2)(ii). The current blood gas studies of record are summarized below:

DATE	EX. NO.	PHYSICIAN	pCO_2	pO_2	QUALIFIES
6/28/00	DX 47	Talati	36 31*	84 105*	No " *
11/2/00	EX 7	Hertz	40 38*	84 84*	No " *
2/22/02	EX 17	Dittman	39 38*	77 80*	No " *

*post-exercise

Under §§718.204(c)(3) and 718.204(b)(2)(iii), total disability can be established where the miner has pneumoconiosis and the medical evidence shows that he suffers from cor pulmonale with right-sided congestive heart failure. There is no record evidence of cor pulmonale with right-sided congestive heart failure. Therefore, Claimant has failed to establish total disability under §718.204(b)(2)(iii).

The remaining means of establishing total disability is with the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful work. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. §718.204(b)(2)(iv).

Before returning to the current statements of the physicians regarding the disability question, the nature of Claimant's coal mine employment during his last year of such employment must be considered. At the hearing on June 8, 1999, Claimant testified that in his work in strip mining he ran a pay loader, was an oiler on a bucket shovel or dragline, and used a jackhammer in the mine pits that were 80 to 90 feet deep. Claimant stated that his duties included replacing bucket teeth that weighed about 90 pounds and climbing up the boom up to 165 feet to oil it. (DX 40, pp. 30-32) I find that this work was of a heavy exertional nature.

Dr. Talati opined — based on his examination on June 20, 2000, and the laboratory studies performed on June 28, 2000 — that Claimant was precluded from working in his usual coal mine employment due to pneumoconiosis. (DX 47) Although Dr. Talati noted that Claimant became short of breath during the exercise portion of the blood gas study, the physician's pulmonary examination of Claimant was normal, the blood gas study indicated a 99 percent oxygen saturation level, and the ventilatory study indicated only a mild obstructive airways impairment. I find that the opinion of Dr. Talati is highly problematic because it appears to be clearly supported only by Claimant's symptom of shortness of breath. Indeed, Dr. Talati did not clearly reveal what he relied on in arriving at his opinion. In addition, Dr. Talati noted that the FEV-1 in the ventilatory study and the FEV-1/FVC ration were only slightly reduced, and the FVC was normal. Further, there was no oxygen desaturation or hypoxemia shown on

the blood gas testing, according to the physician. Finally, Dr. Talati noted that the EKG performed at that time indicated that Claimant had undergone an anterior septal infarction. However, Claimant reported no symptoms to the physician and the triple bypass surgery that Claimant later underwent — indicating that Claimant may have had undetected heart problems— was still a year away.

In his deposition on June 20, 2000, Dr. Levinson stated the opinion that Claimant had no respiratory condition caused by coal dust, was not totally disabled by any condition caused by exposure to coal dust, and was not totally disabled from a pulmonary standpoint. (DX 51, pp. 36-37) However, as noted above, Dr. Levinson relied on outdated medical evidence. Therefore, I find that his opinion regarding disability is entitled to little if any weight.

In his report dated April 18, 2001, Dr. Kruk opined that Claimant was totally disabled due to coal workers' pneumoconiosis. (EX 4) Dr. Kruk referred to unspecified earlier laboratory testing and to Claimant's symptoms and coal mine employment history. As Dr. Kruk did not provide a clear foundation for his opinion, I find that it is not reasoned and documented.

In Dr. Kraynak's deposition on May 4, 2001 he opined that Claimant is totally disabled due to pneumoconiosis. I find that the physician's opinion is not reasoned or documented for the following reasons. First and foremost, Dr. Kraynak relied on the qualifying ventilatory studies performed on September 14, 2000 and September 13, 2001, which I have found to be invalid. In addition, Dr. Kraynak noted that Claimant reported no cardiac complaints and the physician opined that Claimant had no heart disease in his testimony on May 4, 2001. (CX, pp. 5, 18) The fact that Claimant underwent triple coronary bypass surgery two months after the physician's testimony reveals that Dr. Kraynak was unaware of a condition that could have had a great bearing on Claimant's respiratory symptoms.

Dr. Hertz, in his report dated November 12, 2000, opined that Claimant had only a mild pulmonary impairment. (EX 7) In his report dated December 12, 2000 and his deposition on June 26, 2001, the physician stated Claimant had no disability from a pulmonary standpoint, relying on the ventilatory and blood gas testing on November 2, 2000, and noting that the blood gas study was entirely normal. (EX 8, 16) While Dr. Hertz stated that Claimant's effort was less than optimal in the pulmonary function test performed for the physician on November 2, 2000, Dr. Hertz stated that the study resulted in only a very mild abnormality "which demonstrates that [Claimant] has quite satisfactory pulmonary reserve." Dr. Hertz also noted that when Claimant's oxygen level was tested by oximetry by having him walk 200 to 250 feet, there was no hemoglobin desaturation or decreased oxygen level. The physician also stated that although the etiology of Claimant's shortness of breath and poor exercise tolerance is unclear, there were nonspecific findings on the physician's EKG, but no overt evidence of coronary artery disease. Therefore, and because of Claimant's age, Dr. Hertz recommended that Claimant have further cardiac evaluation" to rule out a cardiac cause" for his symptoms. (EX 8) The wisdom of Dr. Hertz's suggestions are borne out by the fact that only eight months later Claimant's cardiac condition required him to undergo triple bypass surgery.

In his deposition on June 26, 2001, Dr. Hertz reiterated the foregoing, noting that Claimant's coal mine employment involved heavy work. (EX 16, p. 8, 23-24) The physician also stated that even if the pulmonary function test of November 2, 2000 is invalid for technical reasons, it provides clinical information that can be interpreted. Dr. Hertz testified that in the study Claimant demonstrated an FVC of 3 liters and an FEV-1 of 2 liters, which could not be faked. The physician

opined that the foregoing indicate that Claimant has a very well preserved lung function that does not support a pulmonary basis for his symptom of shortness of breath with exercise. (EX 16, pp. 33-34, 38-39) In conclusion, Dr. Hertz testified that Claimant should have a more extensive cardiac evaluation since the physician could not find a pulmonary cause for his shortness of breath. (EX 16, pp. 41-42)

In his report dated January 11, 2001, Dr. Simelaro opined that Claimant had "moderately obstructive airways disease," relying primarily on unidentified pulmonary function tests. He stated that Claimant was disabled from all employment. (CX 18) In a letter dated December 4, 2001 the physician stated that Claimant's FVC, FEV-1 and mid flow were "mildly reduced". Again, the ventilatory testing referred to is not specifically identified. Dr. Simelaro reported that pulse oximetry testing revealed oxygen saturation of 98 percent at rest. No mention was made of Claimant's coronary surgery of July 2001. (CX 18) In his deposition on April 9, 2002, Dr. Simelaro testified that Claimant is totally disabled due to moderate obstructive airways disease. He relied on Claimant's symptoms of shortness of breath and cough, as well as the ventilatory testing on December 4, 2001, and other pulmonary function tests that were not specifically identified. (CX 22, pp. 17-18) Dr. Simelaro criticized Dr. Hertz's use of the pulse oximetry testing. Dr. Simelaro noted that at rest the former's test result was oxygen saturation of 96 to 97 percent and that with exercise it dropped to 95 percent. Dr. Simelaro testified that this drop was a "little one" and "not a big deal." However, the physician noted that Dr. Hertz reported that Claimant had become short of breath upon walking 200 to 250 feet during the testing. Dr. Simelaro then characterized this as Claimant "huffed and puffed and was still able to maintain a pretty good oxygen saturation." The physician testified that the fact that Claimant got short of breath was "more of a test than the pulse oximetry." He stated that Dr. Hertz should not have "pushed" Claimant "because you'd probably kill him" and be faced with a malpractice suit. (CX 22, pp.25-27)

Dr. Dittman stated in his report of March 5, 2002, that clinical examination of Claimant's lungs on February 22, 2002 was normal, the pulmonary function test results were "falsely lower" due to less than maximal effort but suggested a mild obstructive defect, and the blood gas study revealed normal oxygenation (95 percent) at rest and with exercise. The physician stated that EKG at that time indicated ischemia. (EX 17) In his deposition on May 3, 2002, the physician testified that the EKG revealed ongoing ischemic despite Claimant having had bypass surgery in July 2001. He stated that Claimant's coronary disease is one of the causes "if not the cause for [Claimant's] shortness of breath." (EX 19, pp. 13-14) Dr. Dittman stated that although his pulmonary function test was technically invalid due to less than maximal effort, the study indicates that with proper effort Claimant would be able to produce normal values, noting that Claimant produced a normal FVC result in the test. The physician stated that false low results can be produced in testing, but not false increased values, and that his reliance on the pulmonary function test is appropriate. (EX 19, pp. 18-21, 38-40) Dr. Dittman opined that Claimant was able to perform his heavy coal mine employment from a pulmonary standpoint. The physician concluded that from a cardiac standpoint Claimant could not return to his coal mine employment. (EX 19, p. 36, 41)

Turning to the consideration of the medical evidence as a whole, I first note that none of the current pulmonary function tests fully conform to the quality requirements of the regulations. However, the FEV-1 and FVC values in Dr. Talati's test of June 28, 2000, have been found acceptable. In addition, Dr. Hertz rationally found that his study, performed on November 2, 2000,

contained useful information that indicated Claimant could test normally if his effort were satisfactory. Dr. Dittman provided a similar reasoned opinion with respect to the study performed on February 22, 2002. I therefore find that the current pulmonary function tests militate against a finding that Claimant is totally disabled. Turning to the current blood gas studies, Dr. Talati's test on June 28, 2000, did not reveal desaturation or hypoxemia. (DX 47) The blood gas studies of November 2, 2000 and February 22, 2002, were found to be normal by Dr. Hertz and Dr. Dittman, respectively. (EX 7, 17) Consequently, I find that the blood gas studies also militate against a finding that Claimant is totally disabled.

Turning to the physicians' current statements, I note that Dr. Talati opined that Claimant was totally disabled due to pneumoconiosis. However, it is unclear what the physician relied on in arriving at this opinion. Dr. Talati's blood gas study indicated no problem in oxygenation and in his pulmonary function test the FVC result was normal and the FEV-1 was only slightly reduced. (DX 47) Indeed, Dr. Talati opined that Claimant had only mild obstructive disease. Further, he was unaware of the coronary disease that only fully manifested itself a year after his examination of Claimant. As noted above, I find that Dr. Talati's opinion is problematic. I therefore give it little weight.

I have also rejected the June 20, 2000 opinion of Dr. Levinson, the April 18, 2001 opinion of Dr. Kruk, and the May 4, 2001 opinion of Dr. Kraynak. (See pp. 14-15, above.)

In weighing the contrary opinions of Drs. Hertz and Simelaro, I find that of Dr. Hertz to be reasoned and documented and that of Dr. Simelaro to be less so. Dr. Hertz cogently explained that his laboratory studies support his finding that Claimant is not totally disabled due to a respiratory or pulmonary condition. On the other hand, Dr. Simelaro relied on unidentified ventilatory studies in addition to his study of December 4, 2001, which I have found to be invalid. Further, although at the end of his deposition Dr. Simelaro stated he knew that Claimant had undergone coronary artery surgery in July 2001, the physician did not provide any explanation of how Claimant's coronary disease factored into his opinion that Claimant was totally disabled. Dr. Simelaro simply stated that the surgery was successful and that Claimant had no cardiac complaints. (CX 22, p. 35) Since it appears from the record that Claimant had no specific cardiac complaints (viz., chest pain) until immediately before he underwent surgery, the absence of such complaints appears to be of minimal diagnostic significance. Further, Dr. Hertz expressed concern about Claimant's cardiac signs before he had the surgery, and Dr. Dittman expressed concern about the indications of continuing ischemia long after the surgery was performed. Another matter that warrants favoring the opinion of Dr. Hertz over that of Dr. Simelaro is the latter's attack on the conclusions Dr. Hertz drew from his oximetry testing of Claimant. Dr. Simelaro conceded that the drop in oxygenation on exercise was insignificant, but criticized Dr. Hertz for allowing Claimant to continue walking after he reported shortness of breath. Dr. Simelaro testified that Claimant "huffed and puffed" in doing so and was at risk of death. However, I find nothing in Dr. Hertz's reports to indicate that Claimant was having a severe breathing problem at that time, and it appears that Dr. Simelaro was over-dramatizing the events in an oblique attempt to discredit the satisfactory oximetry results. In sum, Dr. Simelaro's theatrics in no way refute the admitted fact that the drop in oxygenation on exercise was "not a big deal," in the physician's own words.

I find that Dr. Dittman's opinion — that from a pulmonary standpoint Claimant was able to perform his ususal coal mine employment — is reasoned and documented. This opinion supports that of Dr. Hertz.

One aspect of the statements of Drs. Hertz and Dittman warrants further discussion: their concern about Claimant's cardiac condition and, in particular, Dr. Dittman's unexplained statement that Claimant is totally disabled from a cardiac standpoint. As noted above, §718.204(a)(2002) provides that nonpulmonary and nonrespiratory conditions or disease that cause "a chronic respiratory or pulmonary impairment" must be considered in determining the total disability issue. However, despite a hint or two by Dr. Hertz that Claimant's shortness of breath may be related to his cardiac condition, there is no clear evidence of record that Claimant's cardiac condition has caused a chronic respiratory or pulmonary impairment.

The opinions of Dr. Hertz and Dr. Dittman that Claimant is not totally disabled outweigh the current contrary medical opinions.

Based on the medical evidence as a whole, I find that Claimant has failed to establish that he is totally disabled due to a respiratory or pulmonary condition, pursuant to §718.204(b).

III. CONCLUSION

As Claimant has failed to establish a requisite element of entitlement under the Act, his claim for benefits must be denied.

ATTORNEY FEE

The award of an attorney’s fee is permitted only in cases in which Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for representation services rendered in pursuit of the claim.

ORDER

The claim of Joseph Cress for benefits under the Act is DENIED.

A

Robert D. Kaplan
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefit Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.